Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

TN4719

A. BUILDING 01 - MAIN

B. WING_

01/18/2011

NAME OF PROVIDER OR SUPPLIER

HILLCREST HEALTHCARE- WEST

STREET ADDRESS, CITY, STATE, ZIP CODE

6801 MIDDLEBROOK PIKE KNOXVILLE, TN 37919

		NOXVILLE, IN 3791	9	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATION	L ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMPLETI TE DATE
N 002	1200-8-6 No Deficiencies	N 002		
	During the Life Safety portion of the survey, were no deficiencies cited from 1200-8-6, Standards for Nursing Homes.	there		
			10	
				TO DESCRIPTION AND ALL AS ASSESSED.
on of Her	alth Care Facilities			
ii oi nea	nui Cale Facilities	TITLE	(X6) DATE	

3ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

ATE FORM

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If continuation sheet 1 of 1